South Dakota Board of Nursing
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: (605) 362-2768 ♦ www.nursing.sd.gov

# Reinstatement of Lapsed Nursing License

Please follow instructions carefully to avoid delays in processing your reactivation. If any information is incorrect, incomplete or illegible, processing may be delayed. You will be notified in writing if additional information is required. Upon receipt of all forms and fees your application will be considered for reactivation.

**It is illegal to practice nursing in South Dakota without an active nursing license.**

Your license will expire on your birth date. If not renewed by the expiration date, the license is placed on a lapsed status and must be reinstated prior to resuming practice.

Provisions in law relating to practice without a valid nursing license:

- SDCL 36-9-49: Grounds for denial, revocation or suspension of license
- SDCL 36-9-68: Prohibited Acts – Misdemeanor
- SDCL 36-9-71: Unlicensed practice of nursing as a public nuisance
- SDCL 36-9-47: Reinstatement of lapsed license or certificate –Fee
- ARSD 20:48:03:12: Lapse and reinstatement of License

To REINSTATE your lapsed South Dakota nursing license, **submit the following** to the South Dakota Board of Nursing office:

- Completed ***Application to Reinstate a Lapsed Nursing License***
- Completed ***Employment Verification Form***
- **Fee: $140 ($90 RN/LPN renewal fee + $50 RN/LPN reinstatement/lapsed fee)**
  - Payment should be in the form of a money order or personal check payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A $20 fee will be charged for any insufficient check written.

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# Application to Reinstate a Lapsed Nursing License

I request to REINSTATE each license checked:

- ω SD RN License Number: _____
- ω SD LPN License Number: _____

Why did your nursing license lapse?_____

Have you worked in South Dakota on this lapsed license? _____YES _____NO
If YES, where and when?_____

Name(Last):_____(First):_____(Middle):_____

Name(Other):_____

Address:_____

City:_____State:_____Zip:_____

Telephone(Home):_____(Work):_____(Cell):_____

Date of Birth:_____/_____/_____ Email Address:_____
month day year

## *Declaration of Primary State of Residence*

**I declare _____** to be my primary state of residence. Primary state of residence is where you hold a driver's license, pay taxes and/or vote. This state is referred to as my "home state" under the Nurse Licensure Compact and means that it is my "declared fixed permanent and principal home for legal purposes".

The following can be used to document residency pursuant to the Compact laws and rules.

1. Driver's license with a home address.
2. Voter registration card displaying a home address.
3. Federal income tax return declaring the primary state of residence.
4. Military Form No. 2058 – state of legal residence certificate.
5. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence.

For Office Use Only:

## *Military / Federal Employees*

A federal government/military nurse practicing exclusively in federal or military systems, need only have one license from any state or territory per U.S. federal government/military policy. A federal or military nurse who also practices in a civilian health systems is bound by the Compact law and rules.

A federal/military nurse who has proof of residency in a Compact party state may be issued a Compact license with a multi-state practice privilege. A federal/military nurse who does not have proof of residency in a Compact party state may be issued a single-state license regardless of where the nurse is residing. A military/federal nurse may not hold a multi-state license from more than one Compact state at a time.

**Are you employed by the military or practicing in a Federal institution?**

- ω **Yes**
- ω **No**

## *Disciplinary Information*

**If "YES" is answered to any of the below questions please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion / compliance with court requirements.**

| | | | |
|---|---|---|---|
| **1.** | Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense, other than minor traffic violations, that have not previously been reported to the board? | ❑ Yes | ❑ No |
| **2.** | Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? | ❑ Yes | ❑ No |
| **3.** | Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you? | ❑ Yes | ❑ No |
| **4.** | Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action? | ❑ Yes | ❑ No |
| **5.** | Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity? | ❑ Yes | ❑ No |
| **6.** | Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership? | ❑ Yes | ❑ No |
| **7.** | Have you ever been treated for abuse or misuse of any alcohol or chemical substance since your last renewal? | ❑ Yes | ❑ No |
| **8.** | Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care? | ❑ Yes | ❑ No |
| **9.** | Do you currently owe child support arrearages in the amount of $1000 or more? | ❑ Yes | ❑ No |

**Employment and Education Information:**

What type of nursing degree / credential qualified you for your first U.S. nursing license?

- ω Vocational / Practical Certificate Nursing
- ω Diploma – Nursing
- ω Associate Degree – Nursing
- ω Baccalaureate Degree – Nursing
- ω Master's Degree – Nursing
- ω Doctoral Degree – Nursing

What is your highest level of education?

- ω Vocational / Practical Certificate Nursing
- ω Diploma – Nursing
- ω Associate Degree – Nursing
- ω Associate Degree – Non-Nursing
- ω Baccalaureate Degree – Nursing
- ω Baccalaureate Degree – Non-Nursing
- ω Master's Degree – Nursing
- ω Master's Degree – Non-Nursing
- ω Doctoral Degree – Nursing (PhD)
- ω Doctoral Degree – Nursing Practice (DNP)
- ω Doctoral Degree – Nursing Other
- ω Doctoral Degree – Non-Nursing

Year of initial U.S. Licensure: _____

Country of entry-level education: _____

## What is your employment status?

**Actively employed in nursing or in a position that requires a nurse license (select one)**

- ω Full-time
- ω Part-time
- ω Per diem

**Actively employed in a field other than nursing (select one)**

- ω Full-time
- ω Part-time
- ω Per diem

**Working in nursing only as a volunteer**

- ω

**Unemployed (select one)**

- ω Seeking work as a nurse
- ω Not seeking work as a nurse

**Retired**

- ω

In how many positions are you currently employed as a nurse?

- ω 1
- ω 2
- ω 3 or more

How many hours do you work during a typical week in all your nursing positions?

- ω <10 hours
- ω 11-20 hours
- ω 21-30 hours
- ω 31-40 hours
- ω 41-50 hours
- ω 51-60 hours
- ω >60 hours

Indicate the zip code, city, state and county of your primary employer.

Zip Code: _____
City: _____
State: _____
County: _____

Identify the type of setting that most closely corresponds to your nursing practice position.

- ω Academic Setting
- ω Ambulatory Care Setting
- ω Community Health
- ω Correctional Facility
- ω Home Health
- ω Hospital
- ω Insurance Claims / Benefits
- ω Nursing Home / Extended Care / Assisted Living Facility
- ω Occupational Health
- ω Policy / Planning Regulatory / Licensing Agency
- ω Public Health
- ω School Health Services
- ω Other

Identify the position title that most closely corresponds to your nursing practice position.

- ω Advanced Practice Nurse
- ω Consultant
- ω Nurse Executive
- ω Nurse Faculty
- ω Nurse Manager

- Nurse Researcher
- Staff Nurse
- Other – Health Related
- Other – Non Health Related

Identify the employment specialty that most closely corresponds to your nursing practice position.

- Acute Care/ Critical Care
- Adult Health / Family Health
- Anesthesia
- Community
- Geriatric / Gerontology
- Home Health
- Maternal-Child Health
- Medical / Surgical
- Occupational Health
- Oncology
- Palliative Care
- Pediatrics / Neonatal
- Psychiatric / Mental Health / Substance Abuse
- Public Health
- Rehabilitation
- School Health
- Trauma
- Women's Health
- Other

What percent of your current position involves direct patient care?

- 0%
- 25%
- 50%
- 75%
- 100%

If unemployed, please indicate the reasons.

- Difficulty in finding a nursing position
- Disabled
- Inadequate Salary
- School
- Taking care of home and family
- Other

Formal Education

- ω I am not taking courses toward an advanced degree in nursing
- ω I am currently taking courses toward an advanced degree in nursing

Do you intend to leave / retire from nursing practice in the next 5 years?

- ω Yes
- ω No

Other states in which you have ever held a license:

**Active License:** _____

**Inactive License:** _____

List all states where **currently practicing** nursing, whether physically or electronically:

_____

## *Affidavit*

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

**Signature of Applicant** _____ **Date** _____

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## Verification of Employment

Applicant: Complete the top section of this form then forward to your employer or former employer. This form may be duplicated for additional employment verifications. **Return completed form(s) via fax, email or mail to the South Dakota Board of Nursing.**

To obtain/retain active licensure, a nurse must provide verification of a minimum of 140 hours in a 12-month period OR 480 hours in six years of employment/volunteer work in nursing.

***Please Print***

Name (First): _____ (Middle): _____ (Last): _____

❒ I have been employed / volunteered as a nurse (LPN, RN, CRNA, CNM, CNP or CNS).

❒ I have not been employed as a nurse within the last six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

_____ _____
Signature of Applicant Date

**This Section to be Completed by Employer**
***(Provide Employment Hours Within the Last 6 Years)***
**Note: This section cannot be Signed by the Applicant**

The above-named individual is/was employed/volunteered as a nurse

**From** _____
Month/Date/Year

**To** _____
Month/Date/Year

**Total hours worked in this period:** _____

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

_____ _____
Signature of Agency Representative/Title Date
Who can verify/confirm number of hours employed/volunteered

Name of Employer: _____

Address of Employer: _____

Telephone: _____ Email: _____